UPPER CAPE CHIROPRACTIC ASSOCIATES
Intake Form (4 pages total)

PATIENT INFORMATION

Name_____
Last **First** **Middle Initial**

Address_____
Street, Apt #, PO Box

_____
City **State** **Zip**

Birthdate_____ **SS#**_____

Occupation_____ **Primary Care Physician**_____

May we send your doctor a treatment report?

☐ **Yes (please sign)** _____ ☐ **No**

Whom may we thank for referring you?_____

Are you: ☐**Single** ☐**Married** ☐**Partnered** ☐**Widowed** ☐**Divorced**

Name of Spouse/Partner_____

CONTACT INFORMATION

Patient Phone Numbers

- **Home (_____)** _____
- **Cell (_____)** _____
- **Work (_____)** _____
- **Email**_____

EMERGENCY CONTACT
Name_____
Relationship_____
Home Phone (_____) _____
Work/Cell (_____) _____

INSURANCE INFORMATION

Insurance Co._____ **Subscribers DOB**_____

Subscriber's Name_____

♦ ♦

PATIENT CONDITION

Reason for today's visit_____

Date of injury/first symptoms_____

Are symptoms getting progressively worse?_____

Do they interfere with: ☐**work** ☐**sleep** ☐**daily routine** ☐**recreation**

Activities/ motions that are painful include: ☐**sitting** ☐**standing** ☐**bending** ☐**walking**

☐**other**_____

Treatment you have received for your condition: ☐medications_____

☐injections ☐physical therapy ☐surgery ☐chiropractic

☐other_____

HEALTH HISTORY

Date of last physical exam_____

Current medications_____

Current vitamins/supplements_____

EXERCISE	WORK ACTIVITY	HABITS	
☐None	☐Sitting	☐Smoking	packs per day_____
☐Occasional	☐Standing	☐Alcohol	drinks per wk_____
☐Regular	☐Light Labor	☐Caffeine	cups per day_____
	☐Heavy Labor	☐High Stress	

Please list any hospitalizations/major surgeries:

Date	Description

Please indicate whether you have had any of the following:

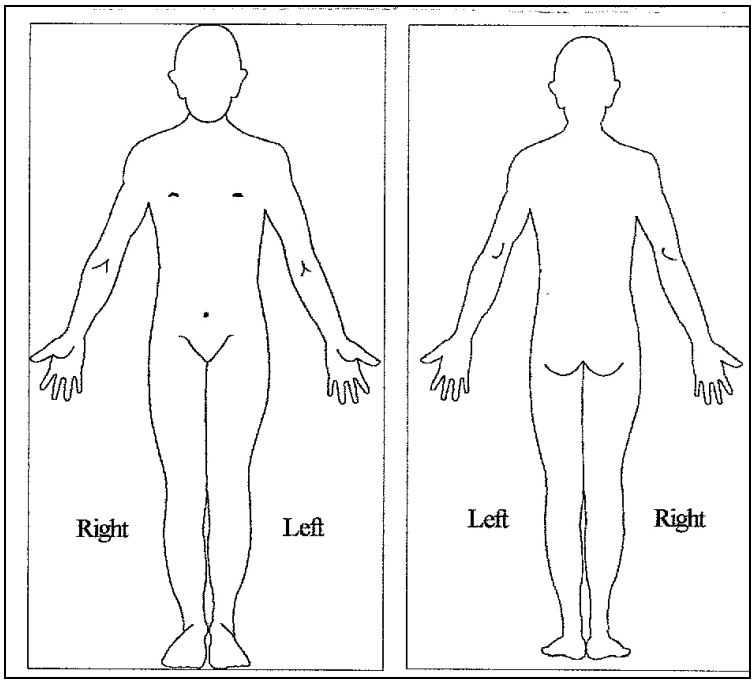
☐AIDS/HIV	☐Chronic fatigue	☐High cholesterol
☐Auto Accident	☐Depression	☐Insomnia
☐Alcoholism	☐Diabetes	☐Kidney disease
☐Allergies	☐Fibromyalgia	☐Liver disease
☐Anemia	☐Fractures	☐Osteoporosis
☐Arthritis	☐Gout	☐Pacemaker
☐Asthma	☐Headaches	☐Stroke
☐Bleeding disorders	☐Heart disease	☐Thyroid problem
☐Cancer	☐Herniated disc	☐Other_____
☐Chemical dependency	☐High blood pressure	_____

Family History: (parents, siblings, grandparents)	☐Arthritis	☐Diabetes
	☐Cancer	☐Heart Disease
		☐High blood pressure

PAIN DIAGRAM

Please use the following symbols to mark affected areas on the diagram below:

Numbness	Pins & Needles	Burning	Aching	Stabbing
^^^^^^^^^	0000	X X X X	+ + + +	/ / / / /



Please rate discomfort on a scale from 0-10 below:

Neck/Shoulder/Arm

0 **10**
None **Severe**

Mid/Low Back

0 **10**
None **Severe**

Leg

0 **10**
None **Severe**

Patient Signature **Date**

Upper Cape Chiropractic Associates
419 Palmer Ave.
Falmouth, MA 02540

Patient_____
File #_____
Date_____

IMPORTANT INFORMATION: PLEASE READ

Contact Authorization

At times our office may need to contact you with appointment reminders, information about treatment or other health related information. Please **check off** the best way to contact you:

□ home phone number:_____
□ work phone number:_____
□ cell phone number:_____
□ email address:_____

Please **place a line** through any of the above methods that you DO NOT want us to use.

I authorize the disclosure of my health information as described above. This notice is effective as of the date below.

_____ _____
Patient (or Guardian) Signature Date

Privacy Notice

We are very concerned with protecting your privacy, especially in matters related to your personal health information. In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPPA) we are required to supply you with a copy of our privacy policies and procedures. We encourage you to read this document carefully, for it outlines the use and limitations of the disclosure of your health information and your rights as a patient. If you ever have any questions or concerns regarding the use or dissemination of your personal health information, we would be happy to address them.

I acknowledge that I have received a copy of the *Notice of Privacy Practices for Protected Health Information* of Upper Cape Chiropractic Associates.

_____ _____
Patient (or Guardian) Signature Date

Authorization to Release and Pay Benefits Direct

I hereby authorize and direct my insurance carrier to pay all benefits which may be due me according to my policy, directly to Upper Cape Chiropractic Associates to be applied towards my account. I understand that **insurance verification is not a guarantee of payment**, it is only a quote of patient benefits. I am also aware that **I will be responsible for paying any balance on my account** including co-pays, co-insurance, deductibles, and any non-covered services. Payment is due within 30 days. A fee of $25.00 will be charged for checks that are returned to us.

I authorize Upper Cape Chiropractic Associates to furnish information to my insurance company regarding my care and treatment in a manner consistent with the privacy policies of this office in obtaining payment for services provided.

_____ _____
Patient (or Guardian) Signature Date